

# **Perinatal Mood And Anxiety Disorders**

By  
Pec Indman EdD, MFT

# HISTORICAL INFORMATION

- Psychiatric history
- History of sexual abuse or trauma
- Fertility problems
- Perinatal loss
- Previous pregnancy, birth, or postpartum difficulties

# IS IT PREGNANCY OR DEPRESSION?

- Mood is labile, teary.  
Self esteem is normal
- Sleep: bladder or heartburn may awaken.  
Can fall asleep
- No suicidal ideology
- Energy: may tire, rest restores
- Pleasure: joy and anticipation  
(appropriate worry)
- Appetite: increases
- Mood: persistent gloom
- Low self-esteem, guilt
- Sleep: early a.m. awakening
- Suicidal thoughts, plans, or intentions
- Energy: rest does not restore. Fatigue
- Anhedonia
- poor appetite

Yonkers K. and Little B, eds. Management of Psychiatric Disorders in Pregnancy, 2001

# DEPRESSION IN PREGNANCY

- About 15-21% of women experience depression in pregnancy up to 38% in low SES (Alfonso DD, et al. Birth 1990;17:121-130)
- 50-75% relapse after discontinuing medication when pregnant (Cohen LS, et al. Psychother Psychosom. 2004 Jul-Aug;73(4):255-8)
- Over 40% resume medication during pregnancy (Cohen LS, et al.. Psychother Psychosom. 2004 Jul-Aug;73(4):255-8)
- Most are undetected and under treated (Marcus, S., Depression during Pregnancy: Rates, Risks, and Consequences. Can J Clin Pharmacol Winter 2009 Vol 16 (1))





# OUTCOMES ASSOCIATED WITH PRENATAL DEPRESSION

- Functional impairment
  - Poor nutrition
  - Inadequate weight gain
  - Adverse behaviors
    - Smoking (20.4%)
    - Alcohol use (18.8%)
    - Drug use (5.5%)
- (Hobfoll SE. et al. Consult Clin Psychol 1995;63:445-53)

# DEPRESSION/ANXIETY IN PREGNANCY

Depression in pregnancy associated with:

- Low birth weight (under 2500 grams)
- Preterm delivery (less than 37 weeks) up to 2X risk (Li D, Liu L, Odouli R, Hum Reprod. 2009 Jan;24(1):146-53. Epub 2008 Oct 23)
- Small-for-gestational age

Severe anxiety in pregnancy associated with:

- Constriction in placental blood supply
- Heightened startle response in newborn
- Newborns more inconsolable, poor sleep

(Bennett HA, Einarson, A. et al. Clin Drug Invest 2004;24 (3)

# MEDICATIONS IN PREGNANCY

- Studies of Prozac, Zoloft, Paxil, Effexor, Anafranil, Deseryl, Serzone, Tricyclics (Bennett HA, Einarson, A. et al. Clin Drug Invest 2004;24 (3)
  - No *increased* risk malformations, miscarriage, neonatal complications or neurobehavioral developmental problems up to 71 mo (Nulman I, Rovet J, Stewart D, et al. Am J Psychiatry 2002;159:1889-18895)
- Congenital anomalies???? (Einarson A, Koren G. Can Fam Physician. 2006 May 10; 52(5): 593–594
- None in prospective, controlled studies (Einarson TR, Einarson A. Newer antidepressants in pregnancy and rates of major malformations: a meta-analysis of prospective comparative studies. *Pharmacoepidemiol Drug Saf.* 2005;14(12):823–827
- None in meta-analyses of those studies (Wogelius et al. 2006)

# SSRI's in PREGNANCY

- “Maternal use of SSRI's during early pregnancy *was not associated with significant increased risks of* craniosynostosis, omphalocele, or heart defects associated with SSRI use overall.”

(NEJM 356;26 June 28, 2007)

- 25,214 deliveries reviewed.  
Exposed congenital cardiac disease 0.4%. Non exposed babies 0.8%  
16% non exposed babies had PPHN.  
None in exposed group.

(Mayo Clin Proc. 2009;84(1):23-27)

# FDA Advisory 7/19/06

- Persistent Pulmonary Hypertension of Newborn  
Noted risk of depression recurrence without medication vs possible risk of PPHN with medication
- **No increased risk** (Antidepressant medication use and risk of persistent pulmonary hypertension of the newborn, Andrade, S, et al. Pharmacoepidemiol. Drug Saf. 2009 January 15)

*“The decision to continue medication or not should be made only after there has been careful consideration of the potential benefits and risks of the medication for each individual pregnant patient.”*



# SSRI'S IN THIRD TRIMESTER

- 2004 FDA warning about perinatal complications
- No reports of serious complications or deaths

Respiratory difficulties most common; transient, benign, often little or no intervention needed (Cohen L. DRUGS, PREGNANCY AND LACTATION: Neonatal Withdrawal Syndrome and SSRIs from ObGynNews)

“Discontinuation of antidepressants during pregnancy can lead to serious maternal morbidity.” G. Koren MD (Koren G, et al. CAMJ. May 2005; (11)172)

(Muzik, M., et al. When Depression Complicates Childbearing: Guidelines for Screening and Treatment During Antenatal and Postpartum Obstetric Care. *Obstet Gynecol Clin N Am.* 2009; 36:771–788)

# NEONATAL ABSTINENCE SYNDROME-SSRI's

- Can occur in up to 30% neonates exposed in utero
- Should monitor/observe up to 48 hrs
- Sx: tremor, GI, respiratory, and sleep disturbance (Rachel Levinson-Castiel, Arch Pediatrics & Adolescent Medicine, volume 160, pages 173-176, February 2006)
- No deaths reported

(Warburton W, Hertzman C, Oberlander TF. A register study of the impact of stopping third trimester selective serotonin reuptake inhibitor exposure on neonatal health. *Acta Psychiatr Scand.* 2009:1–9)

# BIPOLAR DISORDER IN PREGNANCY

- In bipolar women who discontinued meds, 50% relapsed in first 3 months of pregnancy, by 6 months, 70% relapsed (Am J of Psychiatry, 2007 Dec;164(12):1817-24)
- Depakote has up to 5% risk neural tube defects
- Lithium has 0.05% risk of Ebstein's anomaly in 1st trimester. Lamictal looks promising
- Preconception counseling is critical

Viguera, AC., et al. Risk of Recurrence in Women With Bipolar Disorder During Pregnancy: Prospective Study of Mood Stabilizer Discontinuation, *Am J Psychiatry*. 2007;164:1817-1824.



# PSYCHOTHERAPY FOR PRENATAL DEPRESSION

- Interpersonal Psychotherapy (IPT)
- Cognitive-Behavioral therapy
- Psychodynamic therapy not appropriate

*Put out the fire before you  
rewire the house*

# DEPRESSION IN PREGNANCY RISK

- Women depressed at 18 wks gestation had 3x risk of PPD
- Depression at 32 weeks-6x risk

Cohen, LS., et al. Relapse of Major Depression During Pregnancy in Women Who Maintain or Discontinue Antidepressant Treatment. *JAMA*. 2006; 295:499-507.

# POSTPARTUM “BLUES”

- Occurs in 50-80% of postpartum women
- Onset usually in first week postpartum
- Symptoms may persist from several days to a few weeks

NORMAL

# ***BLUES OR BEYOND?***

- Severity
- Timing
- Duration

# POSTPARTUM DEPRESSION

- Occurs in 15-20%, and 26-32% teens

(Currie ML and Radenmacher R, *Pediatr Clin N Am* 2004, 51:785-810, Troutman BR and Cutrona CE, *J Abnorm Psychol.* 1990;99(1):69-78. Marcus, SM., Depression during Pregnancy: Rates, Risks and Consequences. *Can J Clin Pharmacoll. Winter 2009;16 (1):e15-e22.*

- Onset is usually insidious although it can be rapid, and can occur any time in the first year
- Symptoms often peak at 3-6 months
- Can become chronic
- Untreated, 25% still depressed at one year

**postpartum** (Leopold KA and Zoschnick, LB., *The Female Patient.* Aug 1997;22(8):40-49, Wisner, K.L. Timing of depression recurrence in the first year after birth. *J Affect Disord.* 2004; 78(3):249-52 )



# **SYMPTOMS OF POSTPARTUM DEPRESSION/ANXIETY:**

- Sad mood, guilt, irritability, excessive worry, anxiety, or feelings of being overwhelmed
- Sleep problems (often insomnia), fatigue
- Symptoms or complaints in excess of, or without physical cause
- Discomfort around baby, or lack of feelings towards baby
- Loss of focus and concentration (may miss appointments)
- Loss of interest or pleasure
- Appetite changes-poor appetite or weight gain

# RISK FACTORS FOR PPD

- 50-80% risk if previous postpartum depression
- 50% risk if depression or anxiety during pregnancy
- Personal and/or family history of depression or other psychiatric disorder
- History of severe PMS or PMDD
- Social isolation/poor support system/teens/ NICU



# THYROIDITIS OCCURS IN ABOUT 10%

- Lab work to rule out thyroiditis:
  - Free T4
  - TSH
  - Anti-TPO
  - Anti-Thyroglobulin antibodies
  - Best time to test 2-3 mo postpartum

(Stagnaro-Green A., Best Pract Res Clin Endocrinol Metab. 2004  
Jun;18(2):303-16)



# TREATMENT FOR POSTPARTUM DEPRESSION/ANXIETY

- Individual/couples therapy, group & social support CBT or Interpersonal Therapy (IPT)
- Antidepressant and/or antianxiety medication, Sleep meds (Wisner, K.L., et al. Major Depression and Antidepressant Treatment: Impact on Pregnancy and Neonatal Outcomes Medications and Lactation, *AJP in Advance*. 2009; 166:557-566.)
- Treat thyroiditis
- ECT for psychosis, severe depression

**INADEQUATE TREATMENT CAN LEAD TO CHRONIC DEPRESSION OR RELAPSE**

# POSTPARTUM OBSESSIVE-COMPULSIVE DISORDER (OCD)

- 3% to 9% of new mothers may develop obsessive symptoms

(Abramowitz JS, et al. Anxiety Disorders 2003. 17:461-478, Chaudron, LH and Neha Nirodi. The obsessive–compulsive spectrum in the perinatal period: a prospective pilot study. Arch Womens Ment Health, March, 2010;1434-1816)

# SYMPTOMS OF POSTPARTUM OCD

- Intrusive, repetitive, and persistent thoughts or mental pictures
- Thoughts often are about hurting or killing the baby
- Tremendous sense of horror and disgust about these thoughts (ego alien)
- Thoughts may be accompanied by behaviors to reduce the anxiety (such as hiding knives)
- Repetitive counting (diapers in the bag), checking (baby's breathing), cleaning

(Sichel D and Driscoll JW. *Women's Moods*, 1999)

# TREATMENT FOR OCD

- Psychotherapy and psychoeducation
- Medication (SSRIs, Clomipramine, Fluvoxamine)
- Need high doses for SSRIs
- Sometimes low doses of atypical antipsychotics useful

# POSTPARTUM PANIC DISORDER

- May occur in about 10% of postpartum women

# SYMPTOMS OF PANIC DISORDER

- Episodes of extreme anxiety: excessive or obsessive worry or fears
- Shortness of breath, chest pain, sensations of choking or smothering, dizziness
- Hot or cold flashes, trembling, palpitations, numbness or tingling sensations
- Restlessness, agitation, or irritability
- During attack may fear she is going crazy, dying, or losing control
- Attack may awaken her from sleep
- Often no identifiable trigger for panic

(Sichel D and Driscoll JW. *Women's Moods*, 1999)

# TREATMENT FOR PANIC DISORDER

- Psychotherapy & Social Support
- SSRIs
- Antianxiety medication

# POSTTRAUMATIC STRESS DISORDER (PTSD)

- May occur in 1-6% of postpartum women  
(Beck CT. Nursing Research. July/Aug 2004; 53(4):216-224)



# SYMPTOMS OF PTSD

- Recurrent nightmares
- Extreme anxiety
- Reliving past traumatic events
  - sexual
  - physical
  - emotional
  - childbirth

# TREATMENT FOR PTSD

- Psychotherapy & Social Support
- SSRIs and/or antianxiety medication

# BIPOLAR DISORDER

- In women with BD rates range up to 82%
- Time of increased vulnerability for relapse
- Closely associated with postpartum psychosis

(Cohen LS and Nonacs RM eds. *Mood and Anxiety Disorders During Pregnancy and Postpartum*. American Psychiatric Publishing, Inc., 2005, Sharma, V. et al. Bipolar II Postpartum Depression: Detection, Diagnosis, and Treatment. *Am J Psychiatry* 2009; 166:1217–1221.)

# SYMPTOMS OF BIPOLAR

- Mania or hypomania
- Depression
- Rapid and severe mood swings

(Yonkers, K., et al. **Management of Bipolar Disorder During Pregnancy and the Postpartum Period.** Am J Psychiatry 161:608-620, April 2004)

# TREATMENT OF BD

- Prophylaxis with a mood stabilizer or neuroleptic is recommended at the end of pregnancy (36 weeks gestation)
- Careful observation for symptoms
- **High Risk** postpartum mania/psychosis

(Cohen LS and Nonacs RM eds. *Mood and Anxiety Disorders During Pregnancy and Postpartum*. American Psychiatric Publishing, Inc., 2005, Viguera, AC., et al. Risk of Recurrence in Women With Bipolar Disorder During Pregnancy: Prospective Study of MoodStabilizer Discontinuation, *Am J Psychiatry*. 2007;164:1817-1824.)

# POSTPARTUM PSYCHOSIS

- Occurs in 1-2/1000
- 5% suicide and 4% infanticide rate

Miller, L (ed), *Postpartum Mood Disorders* (1999)

# SYMPTOMS OF POSTPARTUM PSYCHOSIS

Usually begins 48-72 hours postpartum

- Most develop symptoms within 2-4 weeks
- Visual or auditory hallucinations
- Early symptoms restlessness, agitation, irritability
- Confusion, paranoia, extreme moodswings
- Delusional thinking (infant death, denial of birth, need to kill baby)

(Suri R and Burt VK., Jrnl Prac Psych and Behav Hlth. March 1997)

# RISK FACTORS FOR POSTPARTUM PSYCHOSIS

- Personal (20-50% risk) and/or family history of psychosis or bipolar disorder
- 80% risk if previous postpartum psychotic or bipolar episode
- First baby

(Suri R and Burt VK., Jnl Prac Psych and Behav Hlth. March 1997, Chaudron LH, Pies RW. The relationship between postpartum psychosis and bipolar disorder: a review. J Clin Psychiatry. 2003 Nov;64(11):1284-92.)



# TREATMENT FOR POSTPARTUM PSYCHOSIS

- REQUIRES **IMMEDIATE HOSPITALIZATION**
- Antipsychotics
- Mood stabilizers (antidepressants as needed)
- Psychotherapy
- ECT

(Yonkers KA, et al.. Am J Psychiatry. 2004;161:608-620)

# WHY TREAT PERINATAL ILLNESS?

- Increased incidence of childhood psychiatric disturbances
- Impaired cognitive and language development in children
- Potential for child abuse and neglect
- Negative impact on marital/family relationships
- Increased risk chronic depression and relapse

(Field T. et al., Infant Behavior & Development 2004;(27) 216-229)

( Hart S. et al., Infant Behavior & Development 1998; 21(3):519-525)

( Murray L and Cooper PJ.,. Psychological Medicine 1997;27(2):253-260)

# BREASTFEEDING AND ANTIDEPRESSANTS

- AAP now recommends 1 year of breastfeeding. Depression preceeds weaning.
- “Paxil and Zoloft usually produce undetectable infant levels.” (Weissman AM. et al. Am J Psychiatry 2004;161:1066-1078)
- Studies of exposed infants show no differences in IQ or neurobehavioral development (Yoshida K, et al. Br J Clin Pharmacol. 1997 Aug;44(2):210-1)

# BREASTFEEDING

- Depressed moms breastfed for shorter durations
- Experienced breastfeeding more negatively than non-depressed (Individual and Combined Effects of Postpartum Depression in Mothers and Fathers on Parenting Behavior. Paulson, Dauber, and Leiferman. Pediatrics, 118(2), Aug 2006:659-668)
- Increased breastfeeding difficulties
- Decreased levels of breastfeeding self-efficacy (Dennis CL & McQueen K. The Relationship Between Infant-Feeding Outcomes and Postpartum Depression. Pediatrics 2009;123:e736-e751)

# RESOURCES

- UIC Perinatal Mental Health Project
  - (800)573-6121
  - [www.psych.uic.edu/research/perinatalmentalhealth](http://www.psych.uic.edu/research/perinatalmentalhealth)
- Other online resources
  - [www.womensmentalhealth.org](http://www.womensmentalhealth.org)
  - [www.mededppd.org](http://www.mededppd.org)
  - [www.toxnet.nlm.nih.gov/](http://www.toxnet.nlm.nih.gov/)
  - [www.reprotox.org](http://www.reprotox.org)
  - [www.motherisk.org](http://www.motherisk.org)

# WHEN SHOULD WE SCREEN?

- Each trimester of pregnancy
- All well-baby checkups in first year
- NICU parents and teens high risk

# FATHERS

- In a national study reported in 2006, 10% of new fathers scored in the range of clinical depression.
- Maternal depression increased the risk of paternal depression.

(Paulson, Dauber, Leiferman, Pediatrics, 2006 Aug;118(2):659-68, Paulson, J.F. and Sharnail D Bazemore. **Prenatal and Postpartum Depression in Fathers and Association With Maternal Depression: A Meta-analysis.** *JAMA.* 2010;303(19):1961-1969)



# TREATMENT GUIDELINES

- Always r/o bipolar spectrum before starting SSRI's.

<http://www.psycheducation.org/depression/MDQ.htm>

- F/U and treat to remission!
  - Educate about length of treatment- set expectations.
- Meds work best *with* therapy or other forms of support

